State of Michigan

Department of Community Health

# 2005–2006 External Quality Review Technical Report

*for*

# Medicaid Health Plans

March 2007

HSAG Health Services Advisory Group

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HSAG HEALTH SERVICES ADVISORY GROUP

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# ACKNOWLEDGMENTS AND COPYRIGHTS

## Purpose of Report

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states to prepare an annual technical report that describes the manner in which data from activities conducted in accordance with 42 Code of Federal Regulations (CFR) 438.358 were aggregated and analyzed. The report must describe how conclusions were drawn as to the quality and timeliness of, and access to, care furnished by the states' managed care organizations, called Medicaid Health Plans (MHPs) in Michigan. The report of results must also contain an assessment of the strengths and weaknesses of the plans with regard to health care quality, timeliness, and access, and must make recommendations for improvement. Finally, the report must assess the degree to which any previous recommendations were addressed by the MHPs. In an effort to meet this requirement, the State of Michigan Department of Community Health (MDCH) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to aggregate and analyze MHP data and prepare the annual technical report.

The State of Michigan contracts with the following MHPs represented in this report:

- **Cape Health Plan** (**CAP**)
- **Community Choice Michigan** (**CCM**)
- **Great Lakes Health Plan** (**GLH**)
- **Health Plan of Michigan, Inc.** (**HPM**)
- **HealthPlus Partners, Inc.** (**HPP**)
- **M-CAID** (**MCD**)
- **McLaren Health Plan** (**MCL**)
- **Midwest Health Plan** (**MID**)
- **Molina Healthcare of Michigan** (**MOL**)
- **OmniCare Health Plan** (**OCH**)
- **Physicians Health Plan of Mid-Michigan Family Care** (**PMD**)
- **Physicians Health Plan of Southwest Michigan** (**PSW**)
- **Priority Health Government Programs, Inc**. (**PRI**)
- **Total Health Care, Inc.** (**THC**)
- **Upper Peninsula Health Plan** (**UPP**)

## Scope of External Quality Review (EQR) Activities Conducted

The EQR technical report analyzes and aggregates data from three mandatory EQR activities and one optional activity as listed below:

- **Compliance Monitoring**: Evaluation of the compliance of the 15 MHPs with federal Medicaid managed care regulations was performed by MDCH using an on-site review process. HSAG examined, compiled, and analyzed the on-site review results, corrective action plans, and annual quality improvement (QI) evaluation/effectiveness reports.
- **Validation of Performance Measures**: Each MHP underwent a National Committee for Quality Assurance (NCQA) HEDIS Compliance Audit™ conducted by an NCQA-licensed audit organization. HSAG performed an independent audit of the audit findings to determine the validity of each performance measure.
- **Validation of Performance Improvement Projects (PIPs)**: HSAG reviewed one PIP for each MHP to ensure that the projects were designed, conducted, and reported in a methodologically sound manner, allowing real improvements in care to be achieved and giving confidence in the reported improvements.
- **Consumer Assessment of Healthcare Providers and Systems (CAHPS)**: MDCH required the administration of the CAHPS 3.0H Adult Medicaid Survey in 2005. Eligible adult members from each MHP who met the enrollment and age criteria during the calendar year completed the survey.

## Summary of Findings

The following is a statewide summary of the conclusions drawn regarding the MHPs' general performance on the four activities.

### *Compliance Review*

Overall, the annual compliance review demonstrated strengths for the MHPs, with appropriate knowledge of processes and documentation of policies and procedures. The statewide average for annual compliance reviews was 89.0 percent. For the six individual standards within the annual compliance review, two statewide averages were above 90.0 percent and the other four were above 80.0 percent. The Administrative and Member standards had 14 out of 15 MHPs score 100 percent, and at least one MHP scored 100 percent for each of the six standards within the annual compliance review.

**Table 1-1—Summary of Data From the 2004–2005 Review of Compliance Review Standards**

| Standards | Range of Scores | Statewide Average |
|---|---|---|
| Standard 1: Administrative | 33%–100% | 97.0% |
| Standard 2: Provider | 50%–100% | 88.5% |
| Standard 3: Member | 25%–100% | 93.9% |
| Standard 4: Quality Assurance/Utilization Review | 60%–100% | 82.8% |
| Standard 5: MIS/Data Reporting/Claims Processing | 40%–100% | 85.5% |
| Standard 6: Fraud and Abuse | 64%–100% | 86.1% |

## Validation of Performance Measures

All of the MHPs demonstrated the capability to calculate and report accurate performance measures specified by the State. The statewide averages for 6 of the 33 performance measures were above the national Medicaid HEDIS 2004 75th percentile, while the rates for 27 of the performance measures were about average, falling between the national Medicaid HEDIS 2004 25th and 75th percentiles. The rates improved for 30 of the 33 performance measures (90.9 percent) compared with rates reported in 2004. None of the statewide averages was below the national Medicaid HEDIS 2004 25th percentile, further evidence that performance measures, in general, were a relative statewide strength.

**Table 1-2—Overall Statewide Average Scores for Performance Measures**

| Performance Measures | 2004 MI Medicaid | 2005 MI Medicaid | Performance Level for 2005 |
|---|---|---|---|
| Childhood Immunization Combo 2 | 67.4% | 72.7% | ★★★ |
| Adolescent Immunization Combo 2 | 34.5% | 54.7% | ★★★ |
| Appropriate Treatment for Children With URI | 75.0% | 76.5% | ★★ |
| Breast Cancer Screening | 54.6% | 54.7% | ★★ |
| Cervical Cancer Screening | 62.6% | 65.5% | ★★ |
| Controlling High Blood Pressure | 53.9% | 60.4% | ★★ |
| Chlamydia Screening 16 to 20 Years | 48.2% | 47.6% | ★★ |
| Chlamydia Screening 21 to 26 Years | 53.8% | 53.1% | ★★ |
| Chlamydia Screening (Combined) | 50.9% | 50.8% | ★★ |
| Diabetes Care—HbA1c Testing | 74.0% | 81.2% | ★★ |
| Diabetes Care—Poor HbA1c Control* | 51.2% | 41.4% | ★★ |
| Diabetes Care—Eye Exam | 42.3% | 50.0% | ★★ |
| Diabetes Care—LDL-C Screen | 74.6% | 83.3% | ★★ |
| Diabetes Care—LDL-C Level <130 | 48.6% | 58.0% | ★★★ |
| Diabetes Care—LDL-C Level <100 | 29.1% | 37.3% | ★★★ |
| Diabetes Care—Nephropathy | 40.7% | 50.1% | ★★ |
| Asthma 5 to 9 Years | 61.0% | 65.1% | ★★ |
| Asthma 10 to 17 Years | 62.5% | 64.2% | ★★ |
| Asthma 18 to 56 Years | 69.5% | 71.8% | ★★★ |
| Asthma Combined Rate | 65.5% | 69.4% | ★★★ |
| Medical Assistance With Smoking Cessation | 66.7% | 68.5% | ★★ |
| Well-Child 1st 15 Months, 0 Visits* | 4.2% | 3.4% | ★★ |
| Well-Child 1st 15 Months, 6+ Visits | 36.8% | 43.5% | ★★ |
| Well-Child 3rd–6th Years of Life | 55.3% | 58.3% | ★★ |

* Lower rates are better for this measure.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

| Table 1-2—Overall Statewide Average Scores for Performance Measures | | | |
|---|---|---|---|
| Performance Measures | 2004 MI Medicaid | 2005 MI Medicaid | Performance Level for 2005 |
| Adolescent Well-Care Visits | 34.2% | 38.5% | ★★ |
| Timeliness of Prenatal Care | 71.5% | 79.2% | ★★ |
| Postpartum Care | 44.9% | 54.8% | ★★ |
| Children's Access 12–24 Months | 91.5% | 92.5% | ★★ |
| Children's Access 25 Months–6 Years | 78.0% | 78.8% | ★★ |
| Children's Access 7–11 Years | 76.7% | 78.9% | ★★ |
| Adolescents' Access 12–19 Years | 74.7% | 78.1% | ★★ |
| Adults' Access 20–44 Years | 75.0% | 77.6% | ★★ |
| Adults' Access 45–64 Years | 82.6% | 84.7% | ★★ |

★ = Below-average performance (<25th percentile) relative to national Medicaid results.
★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.
★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

## Performance Improvement Projects (PIPs)

In general, the highest rates across all activities were for PIPs. All MHPs received a validation status of *Met* or *Partially Met* for the Blood Lead Testing PIP, demonstrating the capability to measure performance and implement and evaluate systematic interventions. The MHPs were at various stages of demonstrating the effectiveness of interventions, as well as demonstrating sustained improvement. Overall, however, performance was considered above average for conducting PIPs.

| Table 1-3—Summary of Data From the Validation of 2005–2006 Blood Lead Testing PIPs | | |
|---|---|---|
| Validation Activity | Number of PIPs Meeting all Evaluation Elements/Number Reviewed | Number of PIPs Meeting all Critical Elements/Number Reviewed |
| Activity I—Appropriate Study Topic | 15/15 | 15/15 |
| Activity II—Clearly Defined, Answerable Study Question | 15/15 | 15/15 |
| Activity III—Clearly Defined Study Indicator | 13/15 | 13/15 |
| Activity IV—Correctly Identified Study Population | 15/15 | 15/15 |
| Activity V—Valid Sampling Techniques | 15/15 | 15/15 |
| Activity VI—Accurate/Complete Data Collection | 10/15 | NA for all MHPs |
| Activity VII—Appropriate Improvement Strategies | 14/14 | 14/14 |
| Activity VIII—Sufficient Data Analysis and Interpretation | 8/14 | 14/14 |
| Activity IX—Real Improvement Achieved | 8/14 | No Critical Elements |
| Activity X—Sustained Improvement | 4/7 | No Critical Elements |

## Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The CAHPS evaluation (Table 1-4 and Table 1-5) showed generally improving, but still about average, performance from a national perspective. Members generally believed they could get needed care, but often it took too long to get the services. Overall, Customer Service was the only one of the measures to average above the national 75th percentile, demonstrating a relative statewide strength. No measure averaged below the national 25th percentile. Compared to 2004, all of the rates showed some improvement. However, all of the CAHPS measures offer additional opportunity for improvement with member satisfaction.

**Table 1-4—Detailed State Average Results for CAHPS 3.0H Composite Scores**

| CAHPS Measures | Top Box Percentage | | Three-Point Mean | | Performance Level for 2005 |
|---|---|---|---|---|---|
| | 2004 | 2005 | 2004 | 2005 | |
| Getting Needed Care | 67.6% | 71.3% | 2.53 | 2.59 | ★★ |
| Getting Care Quickly | 43.6% | 45.2% | 2.15 | 2.18 | ★★ |
| How Well Doctors Communicate | 57.7% | 59.4% | 2.42 | 2.45 | ★★ |
| Courteous and Helpful Office Staff | 63.7% | 66.0% | 2.50 | 2.54 | ★★ |
| Customer Service | 62.9% | 69.0% | 2.51 | 2.60 | ★★★ |

**Note: Top Box denotes percentage who responded "Always" or "Not a Problem"**

★ = Below average performance (<25th percentile) relative to national Medicaid results

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results

★★★ = Above average performance (≥ 75th percentile) relative to national Medicaid results

**Table 1-5—Detailed State Average Scores for CAHPS 3.0H Global Ratings**

| CAHPS Measures | Top Satisfaction Percentage | | Three-Point Mean | | Performance Level for 2005 |
|---|---|---|---|---|---|
| | 2004 | 2005 | 2004 | 2005 | |
| Rating of Personal Doctor | 55.7% | 57.8% | 2.39 | 2.43 | ★★ |
| Rating of Specialist | 58.7% | 59.4% | 2.42 | 2.43 | ★★ |
| Rating of All Health Care | 49.1% | 52.6% | 2.28 | 2.33 | ★★ |
| Rating of Health Plan | 42.9% | 49.9% | 2.15 | 2.28 | ★★ |

**Note: Top satisfaction denotes the percentage of respondents rating 9 or 10 on a scale of 0 to 10.**

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

## Quality, Timeliness, and Access

The assessment of the Quality, Timeliness, and Access domains showed the highest rates were for PIPs, followed by the annual compliance reviews. Both of these areas tended to focus on documentation of processes and should be regarded as MHP strengths. Although the performance measures showed average performance (i.e., between the national 25th and 75th percentiles), in general, these measures also offer the most opportunity for improvement. Improving rates for the performance measures may also improve member satisfaction.

There was little variation in the rates achieved by individual MHPs across the averages within the quality, access, and timeliness domains. This level of consistency suggests that a statewide collaborative project would likely be effective in moving all of the MHPs to higher performance levels. Table 1-6 shows HSAG's assignment of the compliance review standards, performance measures, PIPs, and CAHPS into the domains of Quality, Timeliness, and Access.

**Table 1-6—Assignment of Activities to Performance Domains**

| Compliance Review Standards | Quality | Timeliness | Access |
|---|---|---|---|
| Standard 1. Administrative | ✓ | | |
| Standard 2. Provider | ✓ | ✓ | ✓ |
| Standard 3. Member | ✓ | ✓ | ✓ |
| Standard 4. Quality Assurance/Utilization Review | ✓ | | ✓ |
| Standard 5. MIS/Data Reporting/Claims Processing | ✓ | ✓ | |
| Standard 6. Fraud and Abuse | ✓ | ✓ | ✓ |
| | | | |
| **Performance Measures** | **Quality** | **Timeliness** | **Access** |
| 1. Childhood Immunization Status | ✓ | ✓ | |
| 2. Adolescent Immunization Status | ✓ | ✓ | |
| 3. Appropriate Treatment for Children with Upper Respiratory Infection | ✓ | | |
| 4. Breast Cancer Screening | ✓ | | |
| 5. Cervical Cancer Screening | ✓ | | |
| 6. Controlling High Blood Pressure | ✓ | | |
| 7. Chlamydia Screening in Women | ✓ | | |
| 8. Comprehensive Diabetes Care | ✓ | | |
| 9. Use of Appropriate Medications for People With Asthma | ✓ | | |
| 10. Medical Assistance With Smoking Cessation | ✓ | | |
| 11. Adults' Access to Preventive/Ambulatory Health Services | | | ✓ |
| 12. Children's and Adolescents' Access to Primary Care Practitioners | | | ✓ |
| 13. Prenatal and Postpartum Care | | ✓ | ✓ |
| 14. Well-Child Visits in the First 15 Months of Life | ✓ | | |
| 15. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life | ✓ | | |
| 16. Adolescent Well-Care Visits | ✓ | | |

| Table 1-6—Assignment of Activities to Performance Domains | | | |
|---|---|---|---|
| **PIP Topic** | **Quality** | **Timeliness** | **Access** |
| Blood Lead Testing (Statewide PIP topic for all 15 MHPs) | ✓ | ✓ | |
| | | | |
| **CAHPS Topics** | **Quality** | **Timeliness** | **Access** |
| Getting Needed Care | ✓ | | ✓ |
| Getting Care Quickly | ✓ | ✓ | |
| Customer Service | ✓ | | |
| Courteous and Helpful Office Staff | ✓ | | |
| How Well Doctors Communicate | ✓ | | |
| Rating of Health Plan | ✓ | | |
| Rating of Personal Doctor | ✓ | | |
| Rating of Specialist | ✓ | | |
| Rating of Health Care | ✓ | | |

For MHP-specific strengths, weaknesses, and recommendations, refer to Appendices A–O of this report. For overall State findings see Section 3.

# 2. External Quality Review Activities

## Introduction

This section of the report describes the manner in which data from the activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed.

## Compliance Monitoring

### *Objectives*

According to 42 CFR 438.358, the State or its EQRO must conduct a review within a three-year period to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. In order to meet this requirement, MDCH performed on-site reviews of its MHPs.

The objectives of the evaluation of the contractual compliance with federal Medicaid managed care regulations were to identify any areas of noncompliance and to assist the MHPs in developing plans of corrective action that were deemed acceptable to MDCH in terms of scope, content, and established timelines.

### *Technical Methods of Data Collection*

MDCH was responsible for the activities that assessed MHP compliance with federal Medicaid managed care regulations. The Site Visit Survey Tool used to conduct these evaluations is reviewed annually by MDCH and updated as necessary to incorporate contract changes, and to clarify and consolidate criteria. This report reflects activities from the eighth cycle of on-site visits that included all 15 MHPs and took place from October 1, 2004, through September 30, 2005. Review criteria used by MDCH during the on-site visit included the following six core areas:

1. Administrative: Review of items related to the structure of the organization, and composition, function, and activities of the governing body.
2. Provider: Review of subcontracted and delegated functions, provisions for the scope of covered service, primary care providers, network adequacy, and provider relations.
3. Member: Review of content and distribution of member materials, and processes for handling grievances, appeals, and State fair hearing requests.
4. Quality Assurance/Utilization Review: Addressed practice guidelines, the MHP quality assessment and performance improvement (QAPI) program, access to care, the utilization management program, credentialing/recredentialing protocols, and programs for individuals with special health care needs.

5. MIS/Data Reporting/Claims Processing: Examined information system requirements, financial administrative reporting to MDCH, timeliness of payments, and management of enrollment data.
6. Fraud and Abuse: Evaluated fraud and abuse policies and procedures, risk management methodology, claims auditing processes and utilization trending procedures.

## Description of Data Obtained

To assess the MHPs' compliance with federal and State requirements, MDCH obtained information from a wide range of written documents produced by the MHPs, including:

- Policies and procedures
- Current QAPI program
- Minutes of meetings of the governing body, quality improvement (QI) committee, compliance committee, utilization management (UM) committee, credentialing committee, and peer review committee
- QI work plan, utilization reports, provider and member profiling reports, QI effectiveness report
- Internal auditing/monitoring plan, auditing/monitoring findings
- Claims review reports, prior authorization reports, complaint log, grievance log, telephone contact log, disenrollment log, MDCH hearing requests, medical record review reports
- Provider service and delegation agreements and contracts
- Provider files, disclosure statements, current sanctioned/suspended provider list
- Organizational chart
- Fraud and abuse log, fraud and abuse reports
- Employee handbook, fliers, employee newsletters, provider manuals, provider newsletters, Web site, educational/training materials, and sign-in sheets
- Member materials including welcome letter, member handbook, member newsletters, provider directory, and certificate of coverage
- Provider manual

For each of the 15 MHPs, MDCH prepared site visit reports that contained narrative findings and corrective actions. These findings served as a factual, comprehensive description of evidence used to support the score for each standard.

HSAG examined, compiled, and analyzed the review results as contained in the 15 MHP site visit reports submitted by MDCH. HSAG also evaluated MHP annual QI evaluation/effectiveness reports that addressed the previous year and a work plan that addressed QI initiatives and projects for the upcoming year. As the QI evaluation documents generally covered an earlier time period than the site visit reports, the MHP could not always address the issues identified during the MDCH on-site visit. HSAG's evaluation of the MHPs' QI evaluation documents addressed global findings and recommendations.

## Data Aggregation, Analysis, and How Conclusions Were Drawn

Many of the 55 standards in the tool had substandards or elements that, for the most part, were incorporated into a single score. For each standard reviewed, MHPs received a score based on the following:

- *Pass*, indicating compliance with all elements.
- *Fail*, reflecting lack of compliance with all or critical elements of the standard.
- *Incomplete*, denoting compliance with some, but not all, elements of the standard.
- *Not Reviewed*, indicating that the criterion was reviewed with a passing score at the previous visit, and a letter of attestation was received by MDCH from the plan indicating that there was no change of status.
- *Deemed Status*, showing that the review was deemed compliant based on compliance with the same or similar Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or NCQA accreditation standard.

Scores denoted as *Pass* indicated compliance. Scores of *Fail* and *Incomplete* were not counted toward compliance. HSAG did not include elements in the scoring that were *Not Reviewed* or had a *Deemed Status*.

In addition to the score, narrative findings from the on-site visit were provided. These findings served as a factual, comprehensive description of evidence used to support the score for each standard. The narrative included specific policy citations, data tables, and dated document references.

To draw conclusions and make overall assessments about the quality and timeliness of, and access to, care provided by the MHPs using findings from the initial and follow-up reviews, the standards were categorized to evaluate each of these three domains. HSAG recognizes the interdependence of Quality, Timeliness, and Access, and has assigned each of the standards and record reviews to one or more of the three domains. The BBA, at 42 CFR 438.204(d) and (g) and at 438.320, provides a framework for using findings from EQR activities to evaluate Quality, Timeliness, and Access. Using this framework, Table 2-1 shows HSAG's assignment of standards to the three domains of performance.

**Table 2-1—Assignment of Standards to Performance Domains**

| Standards | Quality | Timeliness | Access |
|---|---|---|---|
| Standard 1. Administrative | ✓ | | |
| Standard 2. Provider | ✓ | ✓ | ✓ |
| Standard 3. Member | ✓ | ✓ | ✓ |
| Standard 4. Quality Assurance/Utilization Review | ✓ | | ✓ |
| Standard 5. MIS/Data Reporting/Claims Processing | ✓ | ✓ | |
| Standard 6. Fraud and Abuse | ✓ | ✓ | ✓ |

# Validation of Performance Measures

## Objectives

As set forth in 42 CFR 438.358, validation of performance measures is one of the mandatory EQR activities. The primary objectives of the performance measure validation process are to:

- Evaluate the accuracy of the performance measure data collected by the MHP.
- Determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure.

To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation to assess each MHP's support systems available to report accurate HEDIS measures.

## Technical Methods of Data Collection and Analysis

MDCH required each MHP to collect and report all Medicaid HEDIS measures. Developed and maintained by the NCQA, HEDIS is a set of performance data broadly accepted in the managed care environment as an industry standard. MDCH identified the calendar year 2004 (reporting year 2005) as the measurement period for validation.

Each MHP underwent an NCQA HEDIS Compliance Audit™ conducted by an NCQA-licensed audit organization. The audit process was performed according to NCQA protocol. The validation team consisted of two individuals selected for their various skill sets, including statistics, analysis, managed care operations, performance measure reporting, information systems assessments, and computer programming capabilities. The HEDIS Compliance Audit was conducted in compliance with NCQA's *2005 HEDIS Compliance Audit: Standards, Policies, and Procedures,* Volume 5. NCQA's HEDIS Compliance Audit is consistent with the CMS protocols for validation of performance measures.

To complete the validation of performance measures process according to the CMS protocols, HSAG performed an independent evaluation of the audit results and findings in order to determine the validity of each performance measure. The HEDIS Compliance Audits, conducted by the licensed audit organizations, included:

**Pre-review Activities**: Each MHP was required to complete the NCQA Baseline Assessment Tool (BAT), which is comparable to the Information Systems Capabilities Assessment Tool, Appendix Z of the CMS protocols. Pre-on-site conference calls were held to follow up on any outstanding questions. The audit team conducted a thorough review of the BAT and supportive documentation, including an evaluation of processes used for collecting, storing, validating, and reporting the performance measure data.

**On- Site Review:** The on-site reviews, which typically lasted two days, included:

- An evaluation of system compliance focusing on the processing of claims and encounters.
- An overview of data integration and control procedures, including discussion and observation.

- A review of how all data sources were combined and the method used to produce the performance measures.
- Interviews with MHP staff members involved with any aspect of the performance measure reporting.
- A closing conference at which the audit team summarized preliminary findings and recommendations.

**Post-On-site Review Activities:** For each performance measure calculated and reported by the MHPs, the audit team aggregated the findings from the pre-on-site and on-site activities to determine whether the reported measures were valid, based on a +/- 5 percent allowable bias. The audit team assigned each measure a designation of *Report* (meaning the measure was determined to be valid and below the allowable threshold for bias), or *Not Report* (meaning the measure was determined to be significantly biased by greater than +/- 5 percent).

## Description of Data Obtained

As identified in the CMS protocol, the following key types of data were obtained and reviewed as part of the validation of performance measures. Table 2-2 shows the data sources used in the validation of performance measures and the time period to which the data applied.

**Table 2-2—Description of Data Sources**

| Data Obtained | Time Period to Which the Data Applied |
|---|---|
| **HEDIS Compliance Audit Reports** were obtained for each MHP, which included a description of the audit process, the results of the information systems findings, and the final audit designations for each performance measure. | CY 2004 (HEDIS 2005) |
| **Performance Measure Reports,** submitted by the MHPs using NCQA's Data Submission Tool, were analyzed and subsequently validated by the HSAG validation team. | CY 2004 (HEDIS 2005) |
| **Previous Performance Measure Reports** were reviewed to assess trending patterns and rate for reasonability. | CY 2003 (HEDIS 2004) |

### Data Aggregation, Analysis, and How Conclusions Were Drawn

HSAG ensured that the following criteria were met prior to accepting any validation results:

- An NCQA-licensed audit organization completed the audit.
- An NCQA-certified HEDIS compliance auditor led the audit.
- The audit scope included all MDCH-selected HEDIS measures.
- The audit scope focused on the Medicaid product line.
- Data were submitted via an auditor-locked NCQA DST.
- A final Audit Opinion, signed by the lead auditor and responsible officer within the licensed organization, was produced.

To draw conclusions and make overall assessments about the quality and timeliness of, and access to, care provided by the MHPs using findings from the validation of performance measures, each measure was categorized to evaluate each of the three domains. HSAG recognizes the interdependence of Quality, Timeliness, and Access, and has assigned each of the performance measures to one or more of the three domains. The BBA, at 42 CFR 438.204(d) and (g) and 438.320, provides a framework for using findings from EQR activities to evaluate Quality, Timeliness, and Access. Using this framework, Table 2-3 shows HSAG's assignment of performance measures to these domains of performance.

**Table 2-3—Assignment of Performance Measures to Performance Domains**

| Performance Measures | Quality | Timeliness | Access |
|---|---|---|---|
| 1. Childhood Immunization Status | ✓ | ✓ | |
| 2. Adolescent Immunization Status | ✓ | ✓ | |
| 3. Appropriate Treatment for Children with Upper Respiratory Infection | ✓ | | |
| 4. Breast Cancer Screening | ✓ | | |
| 5. Cervical Cancer Screening | ✓ | | |
| 6. Controlling High Blood Pressure | ✓ | | |
| 7. Chlamydia Screening in Women | ✓ | | |
| 8. Comprehensive Diabetes Care | ✓ | | |
| 9. Use of Appropriate Medications for People With Asthma | ✓ | | |
| 10. Medical Assistance With Smoking Cessation | ✓ | | |
| 11. Adults' Access to Preventive/Ambulatory Health Services | | | ✓ |
| 12. Children's and Adolescents' Access to Primary Care Practitioners | | | ✓ |
| 13. Prenatal and Postpartum Care | | ✓ | ✓ |
| 14. Well-Child Visits in the First 15 Months of Life | ✓ | | |
| 15. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life | ✓ | | |
| 16. Adolescent Well-Care Visits | ✓ | | |

# Validation of Performance Improvement Projects (PIPs)

## Objectives

As part of its quality assessment and performance improvement program, each MHP is required by MDCH to conduct PIPs in accordance with 42 CFR 438.240. The purpose of the PIPs is to achieve, through ongoing measurements and intervention, significant improvement that is sustained over time in both clinical care and nonclinical areas. This structured method of assessing and improving MHP processes is expected to have a favorable effect on health outcomes and consumer satisfaction. Additionally, as one of the mandatory EQR activities under the BBA, the State is required to validate the PIPs conducted by its contracted Medicaid managed care organizations. To meet this validation requirement for the MHPs, MDCH contracted with HSAG.

The primary objective of PIP validation was to determine each MHP's compliance with requirements set forth in 42 CFR 438.240(b)(1), including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

The MDCH mandated that each MHP conduct a Blood Lead Testing PIP in 2005-2006. The MDCH mandated the parameters of the PIP, and HSAG performed validation activities for each plan's PIP.

## Technical Methods of Data Collection and Analysis

The HSAG validation team consisted, at a minimum, of an analyst with expertise in statistics and study design, and a reviewer with expertise in performance improvement processes. The methodology used to validate PIPs was based on CMS guidelines as outlined in the CMS publication *Validating Performance Improvement Projects, A Protocol for Use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002* (CMS PIP Protocol). Using this protocol, HSAG, in collaboration with MDCH, developed the PIP Summary Form. This form was completed by each MHP and submitted to HSAG for review. The PIP Summary Form standardized the process for submitting information regarding the PIPs and assured that all CMS protocol requirements were addressed.

With MDCH input and approval, HSAG developed a PIP validation tool to ensure uniform assessment of PIPs. Using this tool, HSAG reviewed each of the PIPs for the following 10 CMS protocol activities:

- Activity I. Appropriate Study Topic
- Activity II. Clearly Defined, Answerable Study Question
- Activity III. Clearly Defined Study Indicator(s)
- Activity IV. Correctly Identified Study Population
- Activity V. Valid Sampling Techniques (if sampling was used)
- Activity VI. Accurate/Complete Data Collection

- Activity VII. Appropriate Improvement Strategies
- Activity VIII. Sufficient Data Analysis and Interpretation
- Activity IX. Real Improvement Achieved
- Activity X. Sustained Improvement Achieved

### Description of Data Obtained

The data needed to conduct the PIP validations were obtained from the MHPs' PIP Summary Form. This form provided detailed information about each MHP's PIP as it related to the 10 activities being reviewed and evaluated for fiscal year (FY) 2005–2006.

### Data Aggregation, Analysis, and How Conclusions Were Drawn

Each of the 10 protocol activities consisted of elements necessary for the successful completion of a valid PIP. The elements within each activity were scored by the HSAG review team as *Met*, *Partially Met*, *Not Met*, or *Not Applicable* (*NA*). To assure a valid and reliable review, some of the elements were designated "critical" elements by HSAG. These were elements that HSAG determined had to be *Met* in order for the MHP to produce an accurate and reliable PIP. Given the importance of critical elements to this scoring methodology, any critical element that received a *Not Met* status resulted in an overall validation rating for the PIP of *Not Met* and required future revisions and resubmission of the PIP to HSAG. An MHP would be given a *Partially Met* score if 60 percent to 79 percent of all elements were *Met* across all activities, or one or more critical elements were *Partially Met.* The MHPs had an opportunity to resubmit revised PIP Summary Forms and additional information in response to any *Partially Met* or *Not Met* evaluation scores, regardless of whether the evaluation element was critical or noncritical. The resubmitted documents were evaluated and the PIPs rescored, if applicable.

HSAG followed the above methodology for validating the PIPs for all 15 MHPs in order to assess the degree to which the projects were designed, conducted, and reported in a methodologically sound manner.

After completing the validation review, HSAG prepared a report of the findings and recommendations for each validated PIP. These reports, which complied with 42 CFR 438.364, were forwarded to MDCH and the appropriate MHP.

To draw conclusions and make overall assessments about the quality and timeliness of, and access to, care provided by the MHPs using findings from the validation of PIPs, each PIP was categorized to evaluate each of these three domains. HSAG recognizes the interdependence of Quality, Timeliness, and Access, and has assigned each of the PIPs to one or more of the three domains. The BBA, at 42 CFR 438.204(d) and (g) and 438.320, provides a framework for using findings from EQR activities to evaluate Quality, Timeliness, and Access. The Blood Lead Testing PIP was assigned to Quality and Timeliness.

# Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The CAHPS survey looks at key satisfaction drivers throughout the continuum of care, including health plan performance and the member's experience in the physician's office.

## Objectives

The objective of the CAHPS survey is to effectively and efficiently obtain information on members' levels of satisfaction with their health care experiences.

## Technical Methods of Data Collection and Analysis

The technical method of data collection was through the administration of the Adult CAHPS 3.0H Survey. The survey encompasses a set of standardized items (67 items) that assess patient perspectives on care. To achieve reliability and validity of findings, HEDIS sampling and data collection procedures were followed for the selection of members and the distribution of surveys. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. Data from the multiple waves of mailings and response-gathering activities were aggregated into a database for analysis.

The survey questions were categorized by nine measures of satisfaction. These measures included four global ratings and five composite scores. The global ratings reflected patients' overall satisfaction with their personal doctor, specialist, health plan, and with all health care. The composite scores were derived from sets of questions put in the following groups to address different aspects of care: getting needed care, getting care quickly, how well doctors communicate, courteous and helpful office staff, and customer service. When a minimum of 100 responses for an item were not received, the results of the measure were not applicable for reporting, resulting in a Not Applicable (NA) designation.

For each of the four global ratings, the percentage of respondents who chose the top satisfaction rating (response value of 8, 9, or 10 on a scale of 0 to 10) was calculated. This was referred to as a question summary rate. In addition, a three-point rating mean was calculated. Response values of 0 through 6 were given a score of 1; 7 and 8 a score of 2; and 9 and 10 a score of 3. The three-point rating mean was the sum of the response scores (1, 2, or 3) divided by the total number of responses to the global rating question.

For each of the five composite scores, the percentage of respondents who chose a positive response was calculated. CAHPS questions used in composites were scaled in one of two ways:

- Never/Sometimes/Usually/Always
- Big Problem/Small Problem/Not a Problem

NCQA defined a top box response for these composites as a response of Always or Not a Problem.

A positive response for these composites was defined as a response of Usually and Always, or Not a Problem. This was referred to as a global proportion for the composite scores.

In addition, a three-point composite mean was calculated for each of the composite scores. Scoring was based on a three-point scale. Responses of Always and Not a Problem were given a score of 3, responses of Usually or Small Problem were given a score of 2, and Never/Sometimes/Big Problem responses were given a score of 1. The three-point composite mean was the average of the mean score for each question included in the composite.

Details on the global ratings, composite scores, and national benchmarks are included in the separate CAHPS reports prepared for each MHP by vendors.

### Description of Data Obtained

The Adult Medicaid CAHPS Survey was used to obtain member satisfaction data for members meeting enrollment criteria during the 2005 measurement year.

### Data Aggregation, Analysis, and How Conclusions Were Drawn

The CAHPS questions were summarized by nine measures of satisfaction. These measures were calculated as described above and assigned to the domains of Quality, Timeliness, and Access as shown in Table 2-4.

**Table 2-4—CAHPS Assignment to Performance Domains**

| Topics | Quality | Timeliness | Access |
|---|---|---|---|
| Getting Needed Care | ✓ | | ✓ |
| Getting Care Quickly | ✓ | ✓ | |
| Customer Service | ✓ | | |
| Courteous and Helpful Office Staff | ✓ | | |
| How Well Doctors Communicate | ✓ | | |
| Rating of Health Plan | ✓ | | |
| Rating of Personal Doctor | ✓ | | |
| Rating of Specialist | ✓ | | |
| Rating of Health Care | ✓ | | |

## Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. The objectives of the evaluation of the MHPs' compliance with federal Medicaid managed care regulations were to identify any areas of noncompliance and to assist the MHPs in developing plans of corrective action that were deemed acceptable to MDCH in terms of scope, content, and established timelines. Table 3-1 shows each of the six compliance review standards, the range of scores across the 15 MHPs, and the statewide averages for each of the standards.

**Table 3-1—Summary of Data From the 2004–2005 Review of Compliance Review Standards**

| Standards | Range of Scores | Statewide Average |
|---|---|---|
| Standard 1: Administrative | 33%–100% | 97.0% |
| Standard 2: Provider | 50%–100% | 88.5% |
| Standard 3: Member | 25%–100% | 93.9% |
| Standard 4: Quality Assurance/Utilization Review | 60%–100% | 82.8% |
| Standard 5: MIS/Data Reporting/Claims Processing | 40%–100% | 85.5% |
| Standard 6: Fraud and Abuse | 64%–100% | 86.1% |

Table 3-1 shows that all statewide averages were above 80.0 percent and two were above 90.0 percent. At least one MHP scored 100 percent for each of the six standards within the annual compliance review. After accounting for the strengths seen in categories with statewide averages exceeding 90.0 percent, the remaining four categories were only separated by 5.7 percentage points. These four categories, from highest to lowest statewide average, were Provider, Fraud and Abuse, Management Information System (MIS)/Data Reporting/Claims Processing, and Quality Assurance/Utilization Review. Overall, the annual compliance reviews documented the MHPs' strengths in having appropriate knowledge of processes and documentation of policies and procedures.

**Table 3-2—Distribution of Perfect Scores From the 2004–2005 Review of Standards**

| Standards | Number of MHPs Passing All Elements | Percentage of MHPs Passing All Elements |
|---|---|---|
| Standard 1: Administrative | 14 | 93.3% |
| Standard 2: Provider | 7 | 46.7% |
| Standard 3: Member | 14 | 93.3% |
| Standard 4: Quality Assurance/Utilization Review | 2 | 13.3% |
| Standard 5: MIS/Data Reporting/Claims Processing | 10 | 66.7% |
| Standard 6: Fraud and Abuse | 3 | 20.0% |

Table 3-2 provides the distribution of MHPs scoring 100 percent for each of the categories in the review. Both the Administrative and Member categories had 14 out of 15 MHPs score 100 percent. On the other end of the spectrum, Quality Assurance/Utilization Review had two MHPs score 100 percent and Fraud and Abuse had three perfect scores. From this perspective, Quality Assurance/Utilization Review and Fraud and Abuse form the highest overarching priorities statewide for improving performance on the annual compliance reviews, followed by the elements within the Provider standard that were generally not passed. The majority of MHPs scored 100 percent on each of the other categories.

The data used to create these tables, especially Table 3-1, also presented the following findings from an overall evaluation of the results: the lowest score in four of the six categories (i.e., Administrative, Member, Quality Assurance/Utilization Review, and Fraud and Abuse) was posted by **THC**. **MOL**'s score for the Provider category was the lowest among the MHPs, and **UPP**'s score was the lowest for MIS/Data Reporting/Claims Processing.

Through its reviews and follow-up to plans of correction, the State met the objective to provide information about the MHPs' compliance and noncompliance with Medicaid managed care regulations. Although the range of scores appeared to vary greatly, most of the low scores were from one MHP. Areas of noncompliance were minimal, and corrective actions have been noted, when applicable.

## Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to: evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a thorough information system evaluation to assess the ability of each MHP's support system to report accurate HEDIS measures was performed, as well as a measure-specific review of all reported measures.

The results from the validation of performance measures activity are shown in Table 3-3. For each performance measure, the table shows the percentage and number of MHPs that were assigned a validation status of *Report* (indicating the performance measure was determined to be valid).

**Table 3-3—Summary of Data from Validation of HEDIS 2005 Performance Measures: Percentage and Number of MHPs Achieving Each Validation Status by Measure**

| Performance Measures | Report Status | |
|---|---|---|
| | Percentage of MHPs | Number of MHPs |
| 1. Childhood Immunization Status | 100% | 15 |
| 2. Adolescent Immunization Status | 100% | 15 |
| 3. Appropriate Treatment for Children with Upper Respiratory Infection | 100% | 15 |
| 4. Breast Cancer Screening | 100% | 15 |
| 5. Cervical Cancer Screening | 100% | 15 |
| 6. Controlling High Blood Pressure | 100% | 15 |
| 7. Chlamydia Screening in Women | 100% | 15 |
| 8. Comprehensive Diabetes Care | 100% | 15 |
| 9. Use of Appropriate Medications for People With Asthma | 100% | 15 |
| 10. Medical Assistance With Smoking Cessation | 100% | 15 |
| 11. Adults' Access to Preventive/Ambulatory Health Services | 100% | 15 |
| 12. Children's and Adolescents' Access to Primary Care Practitioners | 100% | 15 |
| 13. Prenatal and Postpartum Care | 100% | 15 |
| 14. Well-Child Visits in the First 15 Months of Life | 100% | 15 |
| 15. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life | 100% | 15 |
| 16. Adolescent Well-Care Visits | 100% | 15 |

The performance data were collected accurately from a wide variety of sources. All of the MHPs demonstrated the capability to calculate and report accurate performance measures that complied with HEDIS specifications. No MHP received a status of *Not Report* (indicating that the performance measure was determined to be not valid).

Table 3-4 on the next page shows each of the performance measures, the rates for each measure for 2004 and 2005, and the categorized performance for 2005 relative to national Medicaid results.

| Table 3-4—Overall Statewide Average Scores for Performance Measures | | | |
|---|---|---|---|
| Performance Measures | 2004 MI Medicaid | 2005 MI Medicaid | Performance Level for 2005 |
| Childhood Immunization Combo 2 | 67.4% | 72.7% | ★★★ |
| Adolescent Immunization Combo 2 | 34.5% | 54.7% | ★★★ |
| Appropriate Treatment for Children With URI | 75.0% | 76.5% | ★★ |
| Breast Cancer Screening | 54.6% | 54.7% | ★★ |
| Cervical Cancer Screening | 62.6% | 65.5% | ★★ |
| Controlling High Blood Pressure | 53.9% | 60.4% | ★★ |
| Chlamydia Screening 16 to 20 Years | 48.2% | 47.6% | ★★ |
| Chlamydia Screening 21 to 26 Years | 53.8% | 53.1% | ★★ |
| Chlamydia Screening (Combined) | 50.9% | 50.8% | ★★ |
| Diabetes Care—HbA1c Testing | 74.0% | 81.2% | ★★ |
| Diabetes Care—Poor HbA1c Control* | 51.2% | 41.4% | ★★ |
| Diabetes Care—Eye Exam | 42.3% | 50.0% | ★★ |
| Diabetes Care—LDL-C Screen | 74.6% | 83.3% | ★★ |
| Diabetes Care—LDL-C Level <130 | 48.6% | 58.0% | ★★★ |
| Diabetes Care—LDL-C Level <100 | 29.1% | 37.3% | ★★★ |
| Diabetes Care—Nephropathy | 40.7% | 50.1% | ★★ |
| Asthma 5 to 9 Years | 61.0% | 65.1% | ★★ |
| Asthma 10 to 17 Years | 62.5% | 64.2% | ★★ |
| Asthma 18 to 56 Years | 69.5% | 71.8% | ★★★ |
| Asthma Combined Rate | 65.5% | 69.4% | ★★★ |
| Medical Assistance With Smoking Cessation | 66.7% | 68.5% | ★★ |
| Well-Child 1st 15 Months, 0 Visits* | 4.2% | 3.4% | ★★ |
| Well-Child 1st 15 Months, 6+ Visits | 36.8% | 43.5% | ★★ |
| Well-Child 3rd–6th Years of Life | 55.3% | 58.3% | ★★ |
| Adolescent Well-Care Visits | 34.2% | 38.5% | ★★ |
| Timeliness of Prenatal Care | 71.5% | 79.2% | ★★ |
| Postpartum Care | 44.9% | 54.8% | ★★ |
| Children's Access 12–24 Months | 91.5% | 92.5% | ★★ |
| Children's Access 25 Months–6 Years | 78.0% | 78.8% | ★★ |
| Children's Access 7–11 Years | 76.7% | 78.9% | ★★ |
| Adolescents' Access 12–19 Years | 74.7% | 78.1% | ★★ |
| Adults' Access 20–44 Years | 75.0% | 77.6% | ★★ |
| Adults' Access 45–64 Years | 82.6% | 84.7% | ★★ |

* Lower rates are better for this measure.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table 3-4 shows the average statewide rate was above the national Medicaid HEDIS 2004 75th percentile for 6 of the 33 performance measures. These measures included both the Childhood and Adolescent Immunization Combo 2, both LDL-C outcome measures (i.e., Level <130, and Level <100), and the Asthma 18 to 56 Years and Combined rates. Statewide, these measures represent areas of strength across the MHPs.

The table also shows that rates for 27 of the performance measures were about average, falling between the national Medicaid HEDIS 2004 25th and 75th percentiles. None of the rates were below the national Medicaid HEDIS 2004 25th percentile, providing further evidence that performance measures, in general, were an area of relative strength for the MHPs statewide.

From a quality improvement perspective, differences in rates need to be evaluated from year to year. The rates reported in 2005 improved for 30 of the 33 performance measures (90.9 percent) over the rates reported in 2004. It should be noted that the rate for Adolescent Immunization Combo 2 increased from 34.5 percent to 54.7 percent between the 2004 and 2005 assessments, indicating a substantive improvement of 20.2 percentage points statewide over the single year.

The rates declined for all three of the Chlamydia screening measures compared to 2004. These measures represent opportunities for improvement statewide. Nonetheless, other important opportunities for improvement statewide could exist that are hidden by the averages presented and assessed in Table 3-4. For this reason, Table 3-5 includes the number of MHPs with rates for performance measures below average, average, and above average for 2005.

**Table 3-5—Distribution of MHP Performance Compared to National Medicaid Benchmarks**

| Performance Measures | Number of Stars | | |
|---|---|---|---|
| | ★ | ★★ | ★★★ |
| Childhood Immunization Combo 2 | 0 | 2 | 13 |
| Adolescent Immunization Combo 2 | 0 | 1 | 14 |
| Appropriate Treatment for Children With URI | 4 | 9 | 2 |
| Breast Cancer Screening | 5 | 9 | 1 |
| Cervical Cancer Screening | 1 | 11 | 3 |
| Controlling High Blood Pressure | 3 | 8 | 4 |
| Chlamydia Screening 16 to 20 Years | 1 | 10 | 4 |
| Chlamydia Screening 21 to 26 Years | 0 | 10 | 5 |
| Chlamydia Screening (Combined) | 1 | 9 | 5 |
| Diabetes Care—HbA1c Testing | 1 | 8 | 6 |
| Diabetes Care—Poor HbA1c Control* | 1 | 8 | 6 |
| Diabetes Care—Eye Exam | 1 | 8 | 6 |
| Diabetes Care—LDL-C Screen | 0 | 6 | 9 |

* Adjusted for the reversed structure of this indicator.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

| Table 3-5—Distribution of MHP Performance Compared to National Medicaid Benchmarks | | | |
|---|---|---|---|
| Performance Measures | Number of Stars | | |
| | ★ | ★★ | ★★★ |
| Diabetes Care—LDL-C Level <130 | 0 | 8 | 7 |
| Diabetes Care—LDL-C Level <100 | 0 | 6 | 9 |
| Diabetes Care—Nephropathy | 0 | 10 | 5 |
| Asthma 5 to 9 Years | 3 | 5 | 7 |
| Asthma 10 to 17 Years | 3 | 5 | 7 |
| Asthma 18 to 56 Years | 0 | 7 | 8 |
| Asthma Combined Rate | 1 | 7 | 7 |
| Medical Assistance With Smoking Cessation | 0 | 8 | 7 |
| Well-Child 1st 15 Months, 0 Visits* | 5 | 8 | 2 |
| Well-Child 1st 15 Months, 6+ Visits | 3 | 11 | 1 |
| Well-Child 3rd–6th Years of Life | 2 | 13 | 0 |
| Adolescent Well-Care Visits | 0 | 12 | 3 |
| Timeliness of Prenatal Care | 3 | 7 | 5 |
| Postpartum Care | 4 | 10 | 1 |
| Children's Access 12–24 Months | 3 | 9 | 3 |
| Children's Access 25 Months–6 Years | 5 | 10 | 0 |
| Children's Access 7–11 Years | 5 | 10 | 0 |
| Adolescents' Access 12–19 Years | 3 | 12 | 0 |
| Adults' Access 20–44 Years | 1 | 12 | 2 |
| Adults' Access 45–64 Years | 3 | 6 | 6 |

* Adjusted for the reversed structure of this indicator.

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

The table shows that five of the MHPs were below the 25th national percentile for four performance measures. The measures are: Breast Cancer Screening; Well-Child 1st 15 Months, 0 Visits; and Children's Access (25 Months–6 Years and 7-11 Years). These measures, therefore, are recommended as high-priority opportunities for improvement statewide.

Both Immunization Combo 2 measures (i.e., for children and for adolescents), however, are recognized as strengths statewide, with rates for nearly all of the MHPs being above the 75th national percentile.

## Performance Improvement Projects (PIPs)

Table 3-6 presents a summary of the validation results for the 15 MHPs. The table delineates each of the 10 activities from the CMS protocol, shows the number of MHPs meeting all of the evaluation requirements within each of the 10 activities, and presents the number of MHPs that have reached each activity. The table further shows the number of MHPs meeting the critical elements within each of the 10 activities.

**Table 3-6—Summary of Data From the Validation of 2005–2006 Blood Lead Testing PIPs**

| Validation Activity | Number of PIPs Meeting all Evaluation Elements/Number Reviewed | Number of PIPs Meeting all Critical Elements/Number Reviewed |
|---|---|---|
| Activity I—Appropriate Study Topic | 15/15 | 15/15 |
| Activity II—Clearly Defined, Answerable Study Question | 15/15 | 15/15 |
| Activity III—Clearly Defined Study Indicator | 13/15 | 13/15 |
| Activity IV—Correctly Identified Study Population | 15/15 | 15/15 |
| Activity V—Valid Sampling Techniques | 15/15 | 15/15 |
| Activity VI—Accurate/Complete Data Collection | 10/15 | NA for all MHPs |
| Activity VII—Appropriate Improvement Strategies | 14/14 | 14/14 |
| Activity VIII—Sufficient Data Analysis and Interpretation | 8/14 | 14/14 |
| Activity IX—Real Improvement Achieved | 8/14 | No Critical Elements |
| Activity X—Sustained Improvement | 4/7 | No Critical Elements |

All of the MHPs received a validation status of *Met* or *Partially Met* for the Blood Lead Testing PIP, demonstrating the capability to measure performance and implement and evaluate systematic interventions. The MHPs were at various stages of demonstrating the effectiveness of interventions, along with sustained improvement.

Overall, performance was considered above average for conducting PIPs. The table shows high performance in the introductory and early activities, with increasing opportunities for improvement in the later activities. The results from Table 3-6 suggest that certain activities are well-understood by the MHPs (i.e., Activities I, II, IV, V, and VII) and should be considered strengths statewide. Other activities were not as well-understood or documented across the MHPs (i.e., Activities VI, VIII, IX, and X). For example, only four of seven MHPs that reached the final activity passed all of the elements within it. For these reasons, these activities were seen as statewide opportunities for improvement.

## Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for the statewide composite CAHPS scores are shown in Table 3-7. The table presents each of the CAHPS measures, the top box percentages for 2004 and 2005, the three-point mean for 2004 and 2005, and the overall performance level for 2005.

**Table 3-7—Detailed State Average Results for the CAHPS 3.0H Composite Scores**

| CAHPS Measures | Top Box Percentage | | Three-Point Mean | | Performance Level for 2005 |
|---|---|---|---|---|---|
| | 2004 | 2005 | 2004 | 2005 | |
| Getting Needed Care | 67.6% | 71.3% | 2.53 | 2.59 | ★★ |
| Getting Care Quickly | 43.6% | 45.2% | 2.15 | 2.18 | ★★ |
| How Well Doctors Communicate | 57.7% | 59.4% | 2.42 | 2.45 | ★★ |
| Courteous and Helpful Office Staff | 63.7% | 66.0% | 2.50 | 2.54 | ★★ |
| Customer Service | 62.9% | 69.0% | 2.51 | 2.60 | ★★★ |

**Note: Top box denotes the percentage who responded "Always" or "Not a Problem."**

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table 3-7 shows that all five of the top box composite score percentages and three-point means showed improvement in 2005 over 2004. For 2005 statewide, the performance level was above average from a national perspective for one measure, Customer Service. The other four measures were assessed as about average from a national perspective. On balance, all of the rates and means improved, but there were still ample opportunities for improvement for the measures scoring about average from a national perspective (i.e., Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Courteous and Helpful Office Staff).

The scores for global ratings are presented in Table 3-8. The table shows each of the four CAHPS global measures, the top satisfaction percentages for 2004 and 2005, the three-point means for 2004 and 2005, and the overall performance level for 2005.

**Table 3-8—Detailed State Average Scores for the CAHPS 3.0H Global Ratings**

| CAHPS Measures | Top Satisfaction Percentage | | Three-Point Mean | | Performance Level for 2005 |
|---|---|---|---|---|---|
| | 2004 | 2005 | 2004 | 2005 | |
| Rating of Personal Doctor | 55.7% | 57.8% | 2.39 | 2.43 | ★★ |
| Rating of Specialist | 58.7% | 59.4% | 2.42 | 2.43 | ★★ |
| Rating of All Health Care | 49.1% | 52.6% | 2.28 | 2.33 | ★★ |
| Rating of Health Plan | 42.9% | 49.9% | 2.15 | 2.28 | ★★ |

**Note: Top satisfaction denotes the percentage of respondents rating 9 or 10 on a scale of 0 to 10.**

★ = Below-average performance (<25th percentile) relative to national Medicaid results.

★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.

★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.

Table 3-8 shows that all four measures improved from 2004 to 2005. Yet, the 2005 scores for all four measures were about average from a national perspective. This finding suggested opportunities for improvement for all four of the global ratings even though the improvements would be building on prior gains.

The data used to create these tables presented one more finding from an overall evaluation of the results. Two MHPs had the lowest score for three measures, although ties for lowest score occurred for two of the nine measures. These two MHPs were **MCD** and **PMD**. For this reason, it is suggested that opportunities for improvement be a higher priority for these two MHPs than for the other 13 MHPs from the results of the CAHPS assessment.

The State met its objective of obtaining information on members' levels of satisfaction with their health care experience. While member satisfaction showed improvement compared with 2004, eight of nine CAHPS rates showed average satisfaction compared with national Medicaid rates. All nine measures offered additional opportunities for improvement with member satisfaction.

## Conclusions/Summary

The current review of the MHPs showed both strengths and opportunities for improvement statewide. Opportunities for improvement specific to each MHP are discussed in Appendices A–O. For best practices, also highlighted in Appendices A–O, MDCH might consider various methods to generalize the policies and practices responsible for exemplary performance throughout the State.

For the annual compliance review, the Administrative and Member categories showed the highest performance statewide, and 14 of 15 MHPs achieved a perfect score in these categories. By contrast, two MHPs achieved perfect scores for the Quality Assurance/Utilization Review and three MHPs achieved perfect scores for the Fraud and Abuse categories. This finding suggested that these categories were high-priority opportunities for improvement for MHPs statewide, followed by the MIS/Data Reporting/Claims Processing category and the Provider category.

In performance measures, both Combo 2 immunization rates (i.e., Children and Adolescents) emerged as strengths across the State, especially the adolescent rate, which increased from 34.5 percent to 54.7 percent between the 2004 and 2005 assessments. Four measures were shown to be high-priority opportunities for improvement statewide. These measures were: Breast Cancer Screening; Well-Child 1st 15 Months, 0 Visits; and Children's Access (25 Months–6 Years and 7–11 Years).

The PIP evaluation showed higher performance in the introductory and earlier activities, with increasing opportunities for improvement in the later activities statewide. The CMS protocol (Conducting Performance Improvement Projects: A protocol for use in Conducting Medicaid External Quality Review Activities) contains the needed information and examples to assist the MHPs in overcoming their difficulties in the middle and later stages of conducting and documenting a PIP.

The CAHPS evaluation showed generally improving but still about average performance from a national perspective. Overall, Customer Service was the only one of nine measures to average above the 75th national percentile, demonstrating a relative strength statewide. No measure averaged below the 25th national percentile.

Overall, plans performed well on PIPs and the annual compliance reviews. Both of these areas, which tend to focus on documentation of processes, should be regarded as MHP strengths. Although the performance measures showed average performance (i.e., between the national 25th and 75th percentiles), in general, these measures also offered the most opportunity for improvement. Since the performance of each MHP was relatively similar, conducting a statewide collaborative study may improve rates at the statewide and the MHP performance level.